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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

DINA KNORR,

Plaintiff,

v.

NANCY BERRYHILL, Acting

Commissioner of Social Security,¹

Defendant.

Case No. EDCV-16-00648-KES

AMENDED MEMORANDUM

OPINION AND ORDER

Plaintiff Dina Knorr appeals the final decision of the Commissioner denying her application for Social Security benefits. For the reasons stated below, the Commissioner's decision is reversed and remanded for the Commissioner to calculate and award benefits to Plaintiff.

On March 10, 2017, the Court entered an initial Memorandum Opinion and Order reversing and remanding the decision of the Commissioner for an award of benefits. (Dkt. 19.) The Commissioner timely filed a Motion to Alter Judgment under Federal Rule of Civil Procedure 59(e), alleging legal error in the Court's

¹ See Fed. R. Civ. P. 25(d) (“[W]hen a public officer who is a party in an official capacity dies, resigns, or otherwise ceases to hold office while the action is pending[,] ... [t]he officer's successor is automatically substituted as a party.”).

1 decision to remand for an award of benefits, rather than remand for further
2 administrative proceedings. (Dkt. 21.) Plaintiff opposed the motion. (Dkt. 24.)
3 This Amended Memorandum Opinion and Order addresses the arguments raised in
4 the Commissioner's motion, and finds that remand for an award of benefits is
5 nevertheless appropriate.

6 **I.**
7 **BACKGROUND**

8 On September 18, 2012, Plaintiff filed applications for Social Security
9 Disability Insurance Benefits ("DIB") and Supplemental Security Income ("SSI")
10 alleging a disability onset date of October 30, 2009. See Administrative Record
11 ("AR") 52, 142-44. At Plaintiff's request, a hearing was held before an
12 administrative law judge ("ALJ") on June 23, 2014. AR 34-51. The ALJ issued a
13 decision denying benefits on August 11, 2014. AR 18-29, 34-51.

14 The ALJ determined that Plaintiff had severe impairments of a back injury
15 and sacroiliac arthrosis. AR 22. The ALJ found that Plaintiff's gastroesophageal
16 reflux disease (GERD), affective disorder, and depression were non-severe.
17 AR 22-24, 26-27. The ALJ concluded that the combination of these impairments
18 did not meet or medically equal the severity of one of the listed impairments set
19 forth in the Listing of Impairments ("Listing") set forth at 20 C.F.R., Part 404,
20 Subpart P, Appendix 1. AR 24.

21 The ALJ determined that Plaintiff had the residual functional capacity
22 ("RFC") to perform sedentary work, except that (1) she is limited to sitting for 30
23 minutes at one time and then would need to be able to stand/stretch for a few
24 seconds, and (2) she is capable of performing occasional postural maneuvers.
25 AR 24. This RFC was consistent with the opinions of two non-examining State
26 agency physicians, which the ALJ gave great weight, but was less restrictive than
27 the opinion of Plaintiff's treating physician, Dr. Gregory D. Carlson, which the ALJ
28 gave little weight. AR 27. The ALJ also relied on the opinion of Dr. Neil J.

1 Halbridge, who examined Plaintiff and performed a disability analysis under
2 California Worker's Compensation regulations. AR 26-27.

3 With this RFC, the ALJ found that Plaintiff was unable to perform her past
4 relevant work as a registered nurse and clinical coordinator. AR 27. However, the
5 ALJ found that jobs exist in significant numbers in the national economy that she
6 could perform, such as information clerk, charge account clerk, and bench
7 assembler. AR 28. Accordingly, the ALJ concluded that Plaintiff had not been
8 under a disability, as defined in the Social Security Act, from October 30, 2009
9 through the date of the decision. AR 29.

10 Plaintiff asked the Appeals Council to review the ALJ's decision, but the
11 Appeals Council declined on February 11, 2016. AR 1-6, 14-16. On that date, the
12 ALJ's decision became the final decision of the Commissioner. See 42 U.S.C.
13 § 405(h). This timely civil action followed.

14 II.

15 STANDARD OF REVIEW

16 Under 42 U.S.C. § 405(g), a district court may review the Commissioner's
17 decision to deny benefits. The ALJ's findings and decision should be upheld if
18 they are free from legal error and are supported by substantial evidence based on
19 the record as a whole. 42 U.S.C. § 405(g); Richardson v. Perales, 402 U.S. 389,
20 401 (1971); Parra v. Astrue, 481 F.3d 742, 746 (9th Cir. 2007). Substantial
21 evidence means such relevant evidence as a reasonable person might accept as
22 adequate to support a conclusion. Richardson, 402 U.S. at 401; Lingenfelter v.
23 Astrue, 504 F.3d 1028, 1035 (9th Cir. 2007). It is more than a scintilla, but less
24 than a preponderance. Lingenfelter, 504 F.3d at 1035 (citing Robbins v. Soc. Sec.
25 Admin., 466 F.3d 880, 882 (9th Cir. 2006)). To determine whether substantial
26 evidence supports a finding, the reviewing court "must review the administrative
27 record as a whole, weighing both the evidence that supports and the evidence that
28 detracts from the Commissioner's conclusion." Reddick v. Chater, 157 F.3d 715,

1 720 (9th Cir. 1998). “If the evidence can reasonably support either affirming or
2 reversing,” the reviewing court “may not substitute its judgment” for that of the
3 Commissioner. Id. at 720-21.

4 “A decision of the ALJ will not be reversed for errors that are harmless.”
5 Burch v. Barnhart, 400 F.3d 676, 679 (9th Cir. 2005). Generally, an error is
6 harmless if it either “occurred during a procedure or step the ALJ was not required
7 to perform,” or if it “was inconsequential to the ultimate nondisability
8 determination.” Stout v. Comm’r, Soc. Sec. Admin., 454 F.3d 1050, 1055 (9th Cir.
9 2006).

10 **A. The Evaluation of Disability.**

11 A person is “disabled” for purposes of receiving Social Security benefits if he
12 is unable to engage in any substantial gainful activity owing to a physical or mental
13 impairment that is expected to result in death or which has lasted, or is expected to
14 last, for a continuous period of at least 12 months. 42 U.S.C. § 423(d)(1)(A);
15 Drouin v. Sullivan, 966 F.2d 1255, 1257 (9th Cir. 1992). A claimant for disability
16 benefits bears the burden of producing evidence to demonstrate that he was
17 disabled within the relevant time period. Johnson v. Shalala, 60 F.3d 1428, 1432
18 (9th Cir. 1995).

19 **B. The Five-Step Evaluation Process.**

20 The ALJ follows a five-step sequential evaluation process in assessing
21 whether a claimant is disabled. 20 C.F.R. §§ 404.1520(a)(4), 416.920(a)(4); Lester
22 v. Chater, 81 F.3d 821, 828 n. 5 (9th Cir. 1996). In the first step, the Commissioner
23 must determine whether the claimant is currently engaged in substantial gainful
24 activity; if so, the claimant is not disabled and the claim must be denied. 20 C.F.R.
25 §§ 404.1520(a)(4)(i), 416.920(a)(4)(i).

26 If the claimant is not engaged in substantial gainful activity, the second step
27 requires the Commissioner to determine whether the claimant has a “severe”
28 impairment or combination of impairments significantly limiting his ability to do

1 basic work activities; if not, a finding of not disabled is made and the claim must be
2 denied. Id. §§ 404.1520(a)(4)(ii), 416.920(a)(4)(ii).

3 If the claimant has a “severe” impairment or combination of impairments, the
4 third step requires the Commissioner to determine whether the impairment or
5 combination of impairments meets or equals an impairment in the Listing set forth
6 at 20 C.F.R., Part 404, Subpart P, Appendix 1; if so, disability is conclusively
7 presumed and benefits are awarded. Id. §§ 404.1520(a)(4)(iii), 416.920(a)(4)(iii).

8 If the claimant’s impairment or combination of impairments does not meet or
9 equal an impairment in the Listing, the fourth step requires the Commissioner to
10 determine whether the claimant has sufficient residual functional capacity (“RFC”)
11 to perform his past work; if so, the claimant is not disabled and the claim must be
12 denied. Id. §§ 404.1520(a)(4)(iv), 416.920(a)(4)(iv). The claimant has the burden
13 of proving he is unable to perform past relevant work. Drouin, 966 F.2d at 1257. If
14 the claimant meets that burden, a prima facie case of disability is established. Id.

15 If that happens or if the claimant has no past relevant work, the
16 Commissioner then bears the burden of establishing that the claimant is not
17 disabled because he can perform other substantial gainful work available in the
18 national economy. 20 C.F.R. §§ 404.1520(a)(4)(v), 416.920(a)(4)(v). That
19 determination comprises the fifth and final step in the sequential analysis. Id.
20 §§ 404.1520, 416.920; Lester, 81 F.3d at 828 n. 5; Drouin, 966 F.2d at 1257.

21 **III.**

22 **ISSUES PRESENTED**

23 Plaintiff raises the following two issues:

24 Issue One: Whether the ALJ properly evaluated the medical evidence and
25 the opinion of Plaintiff’s treating orthopedic surgeon, Dr. Carlson.

26 Issue Two: Whether the ALJ properly evaluated Plaintiff’s pain testimony.
27 (Dkt. 18 [Joint Stipulation or “JS”] at 4, 31-32.)
28

1 IV.

2 DISCUSSION

3 A. **Issue One: The ALJ's Stated Reasons for Discounting the Opinion of**
4 **Plaintiff's Treating Physician, Dr. Carlson, Are Not Supported by**
5 **Substantial Evidence, and the Record as a Whole Does Not Contain**
6 **Substantial Evidence that Would Support Giving Dr. Carlson's Opinion**
7 **Little Weight.**

8 1. **Applicable Law.**

9 In deciding how to resolve conflicts between medical opinions, the ALJ must
10 consider that there are three types of physicians who may offer opinions in Social
11 Security cases: (1) those who directly treated the plaintiff, (2) those who examined
12 but did not treat the plaintiff, and (3) those who did not treat or examine the
13 plaintiff. See 20 C.F.R. § 404.1527(c); Lester, 81 F.3d at 830. A treating
14 physician's opinion is generally entitled to more weight than that of an examining
15 physician, which is generally entitled to more weight than that of a non-examining
16 physician. Lester, 81 F.3d at 830. Thus, the ALJ must give specific and legitimate
17 reasons for rejecting a treating physician's opinion in favor of a non-treating
18 physician's contradictory opinion or an examining physician's opinion in favor of a
19 non-examining physician's opinion. Orn v. Astrue, 495 F.3d 625, 632 (9th Cir.
20 2007) (citing Reddick v. Chater, 157 F.3d 715, 725 (9th Cir. 1998)); Lester, 81 F.3d
21 at 830-31 (citing Murray v. Heckler, 722 F.2d 499, 502 (9th Cir.1983)).

22 If the treating physician's opinion is uncontroverted by another doctor, it may
23 be rejected only for "clear and convincing" reasons. Lester, 81 F.3d at 830 (citing
24 Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991)). However, "[t]he ALJ
25 need not accept the opinion of any physician, including a treating physician, if that
26 opinion is brief, conclusory, and inadequately supported by clinical findings."
27 Thomas v. Barnhart, 278 F.3d 947, 957 (9th Cir. 2002); accord Tonapetyan v.
28 Halter, 242 F.3d 1144, 1149 (9th Cir. 2001). The factors to be considered by the

1 adjudicator in determining the weight to give a medical opinion include: “[l]ength
2 of the treatment relationship and the frequency of examination” by the treating
3 physician; and the “nature and extent of the treatment relationship” between the
4 patient and the treating physician. Orn, 495 F.3d at 631 (quoting 20 C.F.R.
5 § 404.1527(d)(2)(i)-(ii)).

6 In determining a claimant’s RFC, the ALJ should consider those limitations
7 for which there is support in the record, but the ALJ need not consider properly
8 rejected evidence of subjective complaints. Bayliss v. Barnhart, 427 F.3d 1211,
9 1217 (9th Cir. 2005) (“Preparing a function-by-function analysis for medical
10 conditions or impairments that the ALJ found neither credible nor supported by the
11 record is unnecessary.”); Batson v. Comm’r of Soc. Sec. Admin., 359 F.3d 1190,
12 1197 (9th Cir. 2004) (“The ALJ was not required to incorporate evidence from the
13 opinions of Batson’s treating physicians, which were permissibly discounted.”).

14 **2. Analysis.**

15 There are three main differences between the RFC assessed by the ALJ and
16 Dr. Carlson’s May 2014 opinion. Compare AR 24-27 (ALJ’s findings) with AR
17 935-39 (Dr. Carlson’s 2014 opinion). First, the ALJ found Plaintiff was limited to
18 sitting for 30 minutes at one time, and then would need to stand and stretch for a
19 few seconds; Dr. Carlson found that Plaintiff was limited to sitting for 15 minutes
20 at one time, and would need to change positions as needed and take unscheduled
21 breaks. Second, both the ALJ and Dr. Carlson found that Plaintiff was limited to
22 occasional postural maneuvers, but Dr. Carlson also found that Plaintiff could never
23 twist or stoop/bend. Third, Dr. Carlson opined that Plaintiff would likely be absent
24 from work about 2 days per month, whereas the ALJ predicted no atypical
25 absenteeism.

26 Plaintiff saw Dr. Carlson approximately once a month between August 2010
27 and May 2014, and he performed two spinal fusion surgeries on her back. See AR
28 608-711, 835-58, 941-66 (treatment notes); AR 762 (first surgery in August 2010);

1 AR 732 (second surgery in April 2012). Under Social Security regulations, the
2 length and extent of this treating relationship mean that his opinion is generally
3 entitled to greater weight than the opinion of a non-examining physician. See 20
4 C.F.R. § 404.1527(c)(2)(i)-(ii); Orn, 495 F.3d at 631. Because Dr. Carlson’s 2014
5 opinion was contradicted by the opinions of two non-examining State agency
6 physicians, who assigned a less restrictive RFC, see AR 53-63, 64-78, the ALJ was
7 required to provide “‘specific and legitimate reasons’ supported by substantial
8 evidence in the record” for rejecting Dr. Carlson’s opinion. Orn, 495 F.3d at 632
9 (quoting Lester, 81 F.3d at 830).

10 The ALJ gave the following reasons for assigning Dr. Carlson’s opinion little
11 weight: (1) it was inconsistent with Dr. Carlson’s treatment notes, which the ALJ
12 characterized as showing “benign physical findings”; (2) it was inconsistent with
13 “objective studies showing no compression and only mild radiculopathy”; and (3) it
14 was inconsistent with Dr. Carlson’s own March 2013 evaluation. AR 27. As
15 discussed below, these stated reasons do not provide substantial evidence for
16 favoring the opinion of the non-examining physicians over Plaintiff’s long-time
17 treating physician.

18 a. Dr. Carlson’s Treatment Notes.

19 After summarizing Dr. Carlson’s treatment notes, see AR 608-711, 835-58,
20 941-66, the ALJ characterized them as inconsistent with Dr. Carlson’s May 2014
21 disability evaluation, see AR 935-39, because the ALJ found the treatment notes
22 “show[ed] benign physical findings.” AR 25-27. The ALJ’s opinion discusses four
23 specific treatment notes.

24 First, the ALJ found that in January 2011, Plaintiff “had normal sensation.”
25 AR 25 (citing Exhibit 8F/62-71 [AR 669-78]). The cited progress reports state:

26 Physical examination shows a mild antalgia to the right. She has
27 *increased tenderness to palpation at the lumbosacral junction and in*
28 *the center portion of her low back.* There is no erythema, warmth, or

1 signs of infection. She has a well-healed incision. *Range of motion is*
2 *unchanged at 70 degrees of flexion, 5 degrees of extension, and 10*
3 *degrees of right and left lateral bend.* There are no motor or sensory
4 deficits noted.

5 AR 669, 675 (emphasis added).

6 Second, the ALJ found that in March 2011, Plaintiff “had a negative straight
7 leg raising test and minimal physical findings.” AR 25 (citing Exhibit 8F/58-61).

8 The cited progress report states:

9 Exam today shows that she has an *area of tenderness at L3-4.* She has
10 *increasing pain with extension or lateral bend to the left.* She has no
11 motor or sensory deficits in the legs. She has a negative straight leg
12 raise.

13 AR 667 (emphasis added).

14 Third, the ALJ found that in July 2011, Plaintiff “presented with a negative
15 straight leg raising test and good range of motion in her hips.” AR 25 (citing
16 Exhibit 8F/46-48 [AR 653-55]). The cited progress report states:

17 Physical examination shows that she [is] *exquisitely tender at the L3-4*
18 *level.* She is nontender above this. She is nontender at the lumbosacral
19 junction. She has *increasing pain with forward bend more than 40*
20 *degrees or extension.* She has negative straight leg raise and good hip
21 range of motion.

22 AR 654.

23 Lastly, the ALJ found that in March 2013, Plaintiff “reported a worsening of
24 her pain” but “her physical findings were benign.” AR 26 (citing Exhibit 13F/3-12
25 [AR 837-46]). The cited progress reports state:

26 Exam today shows that her posture is straight and upright. She has
27 *tenderness across her surgical site and just proximal to this.* She has
28 no frank motor deficits in the legs. She has good hip range of motion.

...

Exam today shows she is *tender at the upper part of her posterior lumbar incision*. She also has a *degree of tenderness in the mid thoracic region* at the bra level at approximately T8 to T10. She has no motor deficits in her legs, although she is describing new numbness and tingling in her feet.

AR 837, 845 (emphasis added).

In describing Dr. Carlson's treatment notes as showing benign physical findings on these four dates, the ALJ omitted material portions of the treatment notes, which are italicized above. Specifically, the ALJ omitted Dr. Carlson's reports of limitations in postural movements, as well as observations of "tenderness" that corroborated Plaintiff's subjective complaints of pain.

b. Objective Studies.

The second reason the ALJ gave for giving Dr. Carlson's opinion little weight was that the opinion was inconsistent with "objective studies showing no compression and only mild radiculopathy." AR 27.

MRIs of the Lumbar Spine in February and August 2011

The ALJ found that in February 2011, an "MRI taken of her lumbar spine did not show any evidence of spinal canal or foraminal stenosis."² AR 25 (citing Exhibit 8F/103-04 [AR 710-11].) This accurately reflects the finding of the doctor

² "The spine is made up of 33 bones. These and the discs between them provide a passage for the spinal cord and nerves. The spinal cord itself connects the nerves of the body to the brain. Spinal stenosis is a narrowing of the passage where the spinal cord runs." Cedars-Sinai, <http://www.cedars-sinai.edu/Patients/Health-Conditions/Spinal-Stenosis.aspx> . "Additional openings called foramen allow the nerves branching from the spinal cord to travel to the arms, legs and other parts of the body. ... [W]ith age and conditions like arthritis, the foramen may become clogged. Bony spurs can develop inside and press on the nerves." Cedars-Sinai, <https://www.cedars-sinai.edu/Patients/Health-Conditions/Foraminal-Stenosis.aspx> .

1 who initially analyzed the MRI on February 23, 2011. AR 711. However, Dr.
2 Carlson disagreed with these findings, and later objective tests indicated that
3 Plaintiff *did* have stenosis.

4 On March 4, 2011, Dr. Carlson opined that the February 2011 MRI
5 “show[ed] some evidence of some enlargement and hypertrophy of the ligaments
6 and new foraminal and lateral recess narrowing at these levels [L3-4].” AR 668.
7 He was “concerned that [Plaintiff’s] increasing back pain and radicular symptoms
8 [were] related to an adjacent level irritability at the facet joints.”³ AR 668. “In
9 order to prove the diagnosis as well as provide a treating effect,” he recommended
10 “a lumbar facet injection aimed at L3-4, right and left.” AR 668. Plaintiff received
11 the recommended lumbar facet injection, AR 665, but reported it “did not give her
12 much relief.” AR 662.

13 In April 2011, Dr. Carlson requested a new objective study, a lumbar
14 diskogram at the L3-4 level. AR 663. However, insurance coverage for this study
15 was denied. AR 661. At this time, as noted supra, Dr. Carlson observed that
16 Plaintiff was “exquisitely tender at the L3-4 level,” and had “increasing pain with
17 forward bend more than 40 degrees or extension,” although she had “a negative
18 straight leg raise and good hip range of motion.” AR 662.

19 In July 2011, Dr. Carlson requested authorization for “a myelogram with post
20 myelography CAT scan” to “help [him] more fully evaluate the neural foraminal
21 channel and the adjacent segments to determine if in fact there is any impingement
22 or compression at the adjacent segments.” AR 654. He explained, “Her [February
23 2011] MRI was of rather poor quality and showed some mild disk dessication.”
24 AR 654. It appears that coverage for this was also denied, as it was not performed.

25 ³ “The vertebral bodies are stacked one on top of another to form the entire
26 structure of the spine. On each side of the vertebral bodies are tiny joints called
27 facet joints.” UCLA Health Neurosurgery, [http://neurosurgery.ucla.edu/facet-joint-](http://neurosurgery.ucla.edu/facet-joint-syndrome)
28 syndrome .

1 In August 2011, Dr. Carlson again opined:

2 [Plaintiff] has had recurrence of her original radiating left leg pain. I
3 am concerned her symptoms are related to a progression of the adjacent
4 level degenerative changes. *I am concerned the poor quality of the MRI*
5 *scan recently performed in February inhibits us from defining this and*
6 *comparing this to the original pre-surgery MRI.* It is notable that in my
7 initial evaluation of [Plaintiff] prior to surgery, I did note she had some
8 mild degenerative changes at the L3-4 level. However, at this level
9 [Plaintiff] did not have evidence of foraminal narrowing, and therefore,
10 this level was not included in the fusion. *It is possible [Plaintiff's]*
11 *ongoing problem is related to advancement or a more symptomatic*
12 *degenerative change at the L3-4 level.* In order to work this up,
13 [Plaintiff] needs a very high-quality closed MRI scan to define any type
14 of neural degenerative changes.

15 AR 650 (emphasis added).

16 A second MRI of the lumbar spine was performed in August 2011. AR 708-
17 09. The ALJ found that this MRI “showed lumbar fixation at the L4-S1 levels with
18 epidural fibrosis without significant impression on the thecal sac as well as
19 degenerative disc disease with mild posterior bulge at the L3-L4 level with facet
20 and ligamentous hypertrophy creating *mild central canal stenosis with mild*
21 *encroachment on both lateral foramina.”* AR 25 (citing Exhibit 8F/101-02 [AR
22 708-09]) (emphasis added). This is consistent with Dr. Carlson’s analysis.

23 AR 647.

24 This second MRI showing degenerative disk disease at the L3-4 level, along
25 with Plaintiff’s continued reports of pain, caused Dr. Carlson to begin considering a
26 second spinal fusion surgery to advance the fusion to the L3-4 level. AR 647.
27 “Before making this determination,” he recommended “a preoperative lumbar
28 diskogram at the L3-4 with a control level at L2-3 and post diskography CAT

1 scanning.” AR 647. At this time, on September 28, 2011, Dr. Carlson examined
2 Plaintiff and observed that she could “stand and walk” but had “discomfort as she
3 move[d] from a sitting to a standing position” and was “quite tender to palpation at
4 the L3-4 level.” AR 646. She also had “increasing pain with forward bend more
5 than 40 degrees as well as extension past neutral” and “on the left at 90 degrees ...
6 [she] develop[ed] increasing discomfort in the left lateral thigh.” AR 646.

7 In February 2012, Dr. Carlson analyzed a new lumbar x-ray and found it
8 confirmed that Plaintiff had “degenerative changes in the intervertebral disk above
9 the previously performed fusion” and “when compared to preoperative x-rays, there
10 is clearly an increase in narrowing at the L3-4 level.” AR 634. He referred
11 Plaintiff to another doctor for a second opinion, and that doctor agreed that the tests
12 showed Plaintiff was “developing stenosis at the L3-4” and there were “changes at
13 L3-4 consistent with disc degeneration.” AR 603. He concurred with Dr. Carlson’s
14 recommendation for a second spinal fusion surgery, if further tests confirmed “that
15 L3-4 is the generator of her pain.” AR 603; see also AR 631. In March 2012, a CT
16 scan confirmed that the “L3-4 discs contribute to [Plaintiff’s] pain complex.”
17 AR 702, 631. Plaintiff ultimately had a second spinal fusion surgery on April 17,
18 2012. AR 732.

19 The ALJ’s opinion does not discuss Dr. Carlson’s disagreement with the
20 February 2011 MRI results, or the later evidence of degenerative disc disease and
21 foraminal narrowing from the objective tests done in February or March 2012.

22 *March 2013 MRI of Lumbar Spine*

23 The ALJ found, “a[n] MRI taken of [Plaintiff’s] lumbar in 2013 after her
24 second surgery showed no significant dural compression or neural foraminal
25 stenosis.” AR 26 (citing Exhibit 11F/1-2 [AR 815-16].) The cited MRI is dated
26 March 13, 2013. AR 815. The doctor who performed it opined that it showed “no
27 significant dural compression or neural foraminal stenosis ... in the lumbar spine.”
28 AR 816.

1 However, regarding the L1-2 disk, the doctor also noted “mild bilateral facet
2 hypertrophy.”⁴ AR 815. When Dr. Carlson reviewed the scan in April 2013, he
3 agreed that it showed “an open spinal canal from L2 to S1,” where Plaintiff had had
4 the fusion surgery, but he also opined: “Of particular note is that there are new
5 degenerative disk desiccation changes.” AR 845. He diagnosed Plaintiff with
6 “early degenerative disk changes, adjacent level of L1-2,” as well as “lumbar
7 radiculitis.” AR 846.

8 *July 2013 Nerve Conduction Study and MRI of Lumbar Spine*

9 The ALJ found that in 2013, after Plaintiff’s second spinal fusion surgery,
10 “nerve conduction studies showed only mild L5 radiculopathy on the left.” AR 26
11 (citing Exhibit 20F/20-24 [AR 960-64].) The cited study is dated July 11, 2013.
12 AR 960. Dr. Carlson reviewed the study in December 2013 and diagnosed Plaintiff
13 with “chronic L5 radiculopathy, left.” AR 947.

14 However, in the same progress report, Dr. Carlson also discussed other
15 objective studies as follows:

16 I have reviewed the SPECT / CT imaging. This demonstrates uptake
17 at the anterior interbody spaces from L2 to S1. This shows no clear
18 evidence of pseudarthrosis in combination with a CT. In fact, this
19 appears solid. Of particular note is [Plaintiff] has a *bright area of*
20 *uptake in the right sacroiliac joint*. The CT scan views of this area
21 show *evidence of sclerosis in the joints suggestive of arthritic changes*.

22 There is mild scoliosis on AP views with intervertebral setting, more
23 on the left part of the disk at L1-2.

24 AR 946-47 (emphasis added). The ALJ’s opinion does not discuss this SPECT /

25 ⁴ “If the facet joint becomes too swollen and enlarged, it may block the
26 openings through which the nerve roots pass, causing a pinched nerve. This
27 condition is called facet hypertrophy.” Cedars-Sinai, [https://www.cedars-](https://www.cedars-sinai.edu/Patients/Health-Conditions/Facet-Joint-Syndrome.aspx)
28 [sinai.edu/Patients/Health-Conditions/Facet-Joint-Syndrome.aspx](https://www.cedars-sinai.edu/Patients/Health-Conditions/Facet-Joint-Syndrome.aspx) .

1 CT imaging.

2 In sum, the objective studies in the record do not provide substantial
3 evidence for giving Dr. Carlson's opinion little weight. Regarding the February
4 2011 MRI of the lumbar spine, the ALJ failed to take into account the evidence
5 contradicting the conclusion of the doctor who initially analyzed the MRI, that there
6 was no spinal canal or foraminal stenosis. AR 711. This contradictory evidence
7 consisted of: (1) Dr. Carlson's disagreement as to the L3-4 vertebrae and his
8 opinion that the February MRI was of poor quality, see AR 668, 654, 650; (2) the
9 results of the August 2011 MRI showing stenosis and degenerative disc disease at
10 L3-4, as confirmed by the initial reviewing doctor, see AR 708-09, Dr. Carlson, see
11 AR 647, and a consulting doctor who recommended a second spinal fusion surgery,
12 see AR 603; and (3) the tests done in February and March 2012, which confirmed
13 these results, see AR 600, 630-31, 634, 702.

14 The ALJ's opinion did not explicitly consider Dr. Carlson's disagreement or
15 the results of the February and March 2012 studies. The ALJ did mention the
16 August 2011 MRI but appeared to dismiss it because the initial reviewing doctor
17 described the degenerative disc disease as "mild." AR 25. Yet two treating doctors
18 relied on the results of this test, as well as Plaintiff's reported pain levels and
19 observable limitations in her postural movements, to recommend spinal fusion
20 surgery. The ALJ also omitted relevant findings from the March 2013 MRI of the
21 lumbar spine and the July 2013 studies, and failed to consider the SPECT / CT
22 imaging from the same period, which confirmed problems in Plaintiff's sacroiliac
23 joint.

24 c. Dr. Carlson's Opinion from March 2013.

25 The ALJ found that Dr. Carlson's May 2014 opinion was entitled to little
26 weight because it was inconsistent with Dr. Carlson's own opinion from March
27 2013, approximately 1 year earlier. AR 26 (citing Exhibit 13F/15-17 [AR 849-51].)
28 Dr. Carlson's progress report dated March 11, 2013 stated as follows:

1 Temporarily totally disabled. In regard to [Plaintiff's] overall
2 impairment, [Plaintiff] has not been able to return to work due to her
3 pain due to the fact that she cannot lift greater than 10 pounds. She is
4 not able to do repetitive bending, stooping, and lifting. She is not able
5 to find a position of comfort, sit, or stand for more than 30 minutes at a
6 time.

7 AR 850. These functional limitations are less restrictive than those in Dr. Carlson's
8 2014 opinion, wherein he opined that Plaintiff was limited to sitting for no more
9 than 15 minutes at one time, would need to change positions at will and take
10 unscheduled breaks, and would likely be absent from work about two days per
11 month. AR 935-39.

12 Plaintiff argues that the 2014 report simply reflects "slightly greater"
13 limitations "because [Plaintiff's] condition has continued to deteriorate and her pain
14 has been confirmed by EMG evidence"; thus, Plaintiff argues, the later opinion is
15 "more informed." (JS at 8.) The Court agrees. Based on Dr. Carlson's treatment
16 notes after March 2013, Plaintiff's continuing reports of pain and objective studies
17 confirming the source of that pain could have reasonably caused Dr. Carlson to
18 assign her a more restrictive RFC in 2014.

19 The treatment notes are summarized as follows:

20 In April 2013, Plaintiff reported "increasing back pain and also
21 pain, numbness, and tingling into the legs." AR 845. Physical
22 examination revealed she was "tender at the upper part of her posterior
23 lumbar incision" and had "a degree of tenderness in the mid thoracic
24 region at the bra level...." AR 845. Dr. Carlson recommended a pain
25 management approach. AR 846. He started her on Cymbalta, and she
26 continued on Norco, Soma, and Medrol. AR 843.

27 In May 2013, Plaintiff continued to describe "increasing
28 symptoms of pain in her back," "feelings of jolting, numbness, and

1 tingling into the feet, particularly now as she [was] walking,” and
2 “difficulty sitting for any length of time.” AR 837. Similarly, in July
3 2013, Plaintiff reported “increasing pain more to the left side” and “pain
4 across her lumbrosacral junction.” AR 965. Dr. Carlson opined the
5 pain could “be related to the sacroiliac joint arthrosis and adjacent
6 levels above her fusion.”⁵ AR 965-66. He recommended “a trial of
7 sacroiliac joint injections to identify sources of pain” and “the use of a
8 lumbar support corset.” AR 966.

9 An electro-diagnostic EMG study conducted on July 11, 2013
10 “reveal[ed] evidence of mild chronic L5 radiculopathy on the left.” AR
11 960, see also AR 958. This study therefore confirmed Plaintiff’s
12 complaints of left-sided pain and numbness.

13 In September and October 2013, on Dr. Carlson’s
14 recommendation, Plaintiff had lumbar and bilateral sacroiliac joint
15 injections. AR 956, 951-52. However, she reported they gave her no
16 relief or only short-term relief. AR 953, 949.

17 In November and December 2013, Dr. Carlson noted that x-rays
18 and a CT scan showed “mild lumbar degenerative disk changes at L1-
19 2,” as well as “mild scoliosis on AP view with intervertebral setting,
20 more on the left part of the disk at L1-2.” AR 947, 950. He diagnosed
21 sacroiliac joint arthrosis, adjacent level degenerative disk disease at L1-
22 2, and chronic, left-sided L5 radiculopathy. AR 950.

23 In February and March 2014, at Dr. Carlson’s recommendation,
24

25 ⁵ “The sacroiliac joint lies next to the bottom of the spine, below the lumbar
26 spine and above the tailbone (coccyx). It connects the sacrum (the triangular bone
27 at the bottom of the spine) with the pelvis (iliac crest).” Cedars-Sinai,
28 <https://www.cedars-sinai.edu/Patients/Health-Conditions/Sacroiliac-Joint-Dysfunction.aspx> .

1 Plaintiff participated in a 4-week “functional restoration program.” AR
2 943, 950. She reported it was “not very beneficial for her overall,”
3 although “she did feel that the physical therapy aspect helped with
4 strengthening and range of motion.” AR 943.

5 Plaintiff continued to complain of “low back pain that radiates
6 into her left leg intermittently, associated with numbness and tingling.”
7 AR 943. Based on CT scans, Dr. Carlson found “no clear evidence of
8 pseudarthrosis,” but a “bright area of uptake in the right sacroiliac
9 joint.” AR 944. In May 2014, Plaintiff returned to Dr. Carlson
10 complaining of “a lot of increasing pain in both her low back and her
11 hip.” AR 941.

12 These treatment records show that, despite the second spinal fusion surgery,
13 Plaintiff developed left-sided radiculopathy, as well as problems at the L1-2 level
14 above her fusion and in the sacroiliac joint below her fusion. Plaintiff’s subjective
15 reports of pain and numbness in these areas were confirmed by the objective test
16 results, which showed evidence of radiculopathy and degenerative disc disease.

17 These new developments explain the more limited RFC that Dr. Carlson
18 assigned to Plaintiff in 2014. Compare Harris v. Astrue, 2009 WL 272864, at *4
19 (C.D. Cal. Feb. 2, 2009) (finding ALJ properly rejected doctor’s opinion as
20 inconsistent with his earlier findings because “the record *contains no explanation*
21 *for the inconsistency*”) (emphasis added); Dominguez v. Colvin, 927 F. Supp. 2d
22 846, 859 (C.D. Cal. 2013) (finding treating doctor’s notes *did “not explain or*
23 *account for the[] differences”* in her two opinions) (emphasis added). Moreover,
24 the differences between Dr. Carlson’s 2013 opinion and his 2014 were not major,
25 but rather reflected more pronounced limitations in the same areas. See Cox v.
26 Astrue, 2012 WL 5467803, at *8 (C.D. Cal. Nov. 9, 2012) (finding ALJ improperly
27 rejected doctor’s opinion as inconsistent with his earlier opinion because “the
28 inconsistencies were minor, not contradictory” and stood “in sharp contrast to

1 Rollins [v. Massanari, 261 F.3d 853, 856 (9th Cir. 2001)], in which the physician
2 had claimed that the plaintiff was disabled but his notes from an earlier examination
3 indicated that the plaintiff was not disabled”). Given the intervening treatment
4 notes and objective tests, there was not substantial evidence to support the ALJ’s
5 finding that Dr. Carlson’s 2014 opinion was unreliable because it was inconsistent
6 with his earlier 2013 opinion.

7 In sum, the three reasons given by the ALJ for assigning Dr. Carlson’s
8 opinion little weight—inconsistencies with Dr. Carlson’s treatment notes, the
9 objective studies, and Dr. Carlson’s earlier opinion—are not supported by
10 substantial evidence. The Court has also considered whether other evidence in the
11 record provides substantial evidence for giving Dr. Carlson’s opinion little weight.
12 As discussed below, the Court finds that there is not.

13 d. Dr. Halbridge’s June 2013 Report.

14 Dr. Neil J. Halbridge examined Plaintiff in connection with her worker’s
15 compensation claim in May 2013, and produced a report detailing his findings in
16 June 2013. AR 869-76. The ALJ found that Dr. Halbridge’s functional capacity
17 assessment differed from Dr. Carlson’s March 2013 progress reports. AR 26. The
18 ALJ therefore appears to have used this as a further reason for giving Dr. Carlson’s
19 ultimate 2014 opinion little weight.

20 Before analyzing Dr. Halbridge’s opinion, the Court notes that “Workers’
21 compensation disability ratings are not controlling in disability cases decided under
22 the Social Security Act, and the terms of art used in the California workers’
23 compensation guidelines are not equivalent to Social Security disability
24 terminology.” Booth v. Barnhart, 181 F. Supp. 2d 1099, 1104 (C.D. Cal. 2002); see
25 also 20 C.F.R. § 404.1504 (“[A] determination made by another agency that you are
26 disabled ... is not binding on us.”). “Proper evaluation of such medical opinions ...
27 present[s] an extra challenge. The ALJ must ‘translate’ terms of art contained in
28 such medical opinions into the corresponding Social Security terminology in order

1 to accurately assess the implications of those opinions for the Social Security
2 disability determination.” Booth, 181 F.Supp.2d at 1106. “While the ALJ’s
3 decision need not contain an explicit ‘translation,’ it should at least indicate that the
4 ALJ recognized the differences between the relevant state workers’ compensation
5 terminology, on the one hand, and the relevant Social Security disability
6 terminology, on the other hand, and took those differences into account in
7 evaluating the medical evidence.” Id.; see, e.g., Guzman v. Colvin, No. CV 13-
8 05380-MAN, 2014 WL 4961696, at *5 (C.D. Cal. Oct. 3, 2014) (“Because the ALJ
9 did not adequately consider the different meanings of the terms used by Dr.
10 Montgomery in the workers’ compensation and Social Security contexts, the ALJ’s
11 reference to Dr. Montgomery’s workers’ compensation findings was not a
12 legitimate reason to discount Dr. Montgomery’s assessment of plaintiff’s RFC.”).

13 The ALJ accurately found that Dr. Halbridge’s May 2013 examination
14 revealed: “a decreased range of motion, a positive straight leg-raising test on the
15 left, hamstring tightness bilaterally, a positive Faber sign on the left and trace
16 positive on the right but also with normal reflexes, motor function, and sensation.”
17 AR 26 (citing Exhibit 14F [AR 871]). Dr. Halbridge determined that Plaintiff was
18 “permanent and stationary with restrictions in repetitive bending, stooping, or
19 lifting and no heavy pushing, pulling or lifting over 15 pounds.” AR 26 (citing
20 Exhibit 14F [AR 873-75]). The ALJ contrasted these restrictions with Dr.
21 Carlson’s assessment from March 2013, which imposed additional limitations of
22 not lifting more than 10 pounds and not being able to sit or stand for more than 30
23 minutes at one time. AR 26 (citing Exhibit 13F/15-17 [AR 849-51]).

24 The additional restrictions imposed by Dr. Carlson were based on Plaintiff’s
25 subjective reports of pain. Dr. Carlson’s March 2013 progress report indicates that
26 the restrictions he imposed were “due to her pain.” AR 850. The findings that the
27 ALJ cited from Dr. Halbridge did not account for Plaintiff’s subjective reports of
28 pain. See Booth, 181 F. Supp. 2d at 1107 (“For workers’ compensation purposes,

1 ... the work capacity index and the subjective factor index are distinct.”). These
2 reports were taken into account in a later October 2013 report, in which he imposed
3 a final disability rating. See AR 875 (June 2013 report, deferring imposing a final
4 disability rating); AR 863 (October 2013 report). In October 2013, Dr. Halbridge
5 opined that Plaintiff

6 has Class III *moderately severe* pain with pain *present most of the time*
7 and may reach an intensity of 9-10/10 on the pain scale, for which the
8 applicant is prescribed analgesic medications and *associated with*
9 *alteration in activities of daily living*, including being dependent on
10 others for performance of housework, doing laundry, shopping and
11 needing assistance with dressing....

12 AR 863 (emphasis added). Under California Workers’ Compensation regulations,
13 “‘severe’ pain would preclude the activity precipitating the pain” and “‘moderate’
14 pain could be tolerated, but would cause marked handicap in the performance of the
15 activity precipitating the pain.” Booth, 181 F. Supp. 2d at 1107 n.8 (citing Cal.
16 Code Regs. Tit. 8, § 9727).

17 When reading these two reports by Dr. Halbridge in their entirety, they are
18 not inconsistent with Dr. Carlson’s functional limitations and therefore do not
19 provide substantial evidence for discounting Dr. Carlson’s opinion. Dr.
20 Halbridge’s findings of nearly constant, moderately severe pain that cause
21 alterations in Plaintiff’s activities of daily living are consistent with Dr. Carlson’s
22 findings. That these reports of pain were incorporated differently into Dr.
23 Halbridge’s analysis simply reflects the difference between a Workers’
24 Compensation analysis of disability and a Social Security analysis of disability, a
25 difference that the ALJ did not acknowledge. Furthermore, as discussed under
26 Issue Two, the record does not contain substantial evidence supporting the ALJ’s
27 finding that Plaintiff’s reports of pain were not credible.

e. Opinions of Non-Examining Physicians.

On February 13, 2013, a non-examining State agency physician, Dr. S. Amon, opined that Plaintiff was not disabled and had the following RFC: limited to sedentary work; lift and/or carry 10 pounds occasionally; lift and/or carry less than 10 pounds frequently; unlimited push and/or pull; stand and/or walk for 2 hours; sit about 6 hours in an 8-hour workday but stand and stretch every 30 minutes for a few seconds; only occasionally climb ramps, stairs, ladders, ropes, or scaffolds; and only occasionally stoop, kneel, crouch, or crawl. AR 60-62. Dr. Amon did not consider either of Dr. Carlson's evaluations discussed above, as those post-date Dr. Amon's evaluation. AR 61 ("There is no indication that there is opinion evidence from any source.").

On July 15, 2013, another non-examining State agency physician, Dr. Antonio Medina, also opined that Plaintiff was not disabled and had the same RFC. AR 74-75. Dr. Medina noted the opinions in the record from treating physician Dr. Carlson and workers' compensation examining physician Dr. Halbridge, but did not comment on them. AR 75-76 ("Source opinion is an issue reserved to the Commissioner.").

As discussed above, it was error for the ALJ to rely on these opinions from the non-examining physicians instead of the opinion of Plaintiff's long-time treating physician, because the ALJ's given reasons for favoring their opinions over Dr. Carlson's were not supported by substantial evidence, and the record as a whole did not contain substantial evidence to discount Dr. Carlson's opinion. "The nonexamining physicians' conclusion, with nothing more, does not constitute substantial evidence, particularly in view of the conflicting observations, opinions, and conclusions of an examining physician." Pitzer v. Sullivan, 908 F.2d 502, 506 (9th Cir. 1990). "[A] treating physician's opinion must be given controlling weight if it is well-supported and not inconsistent with the other substantial evidence in the

1 record.” Lingenfelter, 504 F.3d at 1038 n.10.⁶

2 **B. Issue Two: The ALJ Failed to Give Specific Reasons, Supported by**
3 **Substantial Evidence, for Discrediting Plaintiff’s Pain Testimony.**

4 **1. Applicable Law.**

5 An ALJ’s assessment of symptom severity and claimant credibility is entitled
6 to “great weight.” Weetman v. Sullivan, 877 F.2d 20, 22 (9th Cir. 1989); Nyman v.
7 Heckler, 779 F.2d 528, 531 (9th Cir. 1986). “[T]he ALJ is not required to believe
8 every allegation of disabling pain, or else disability benefits would be available for
9 the asking, a result plainly contrary to 42 U.S.C. § 423(d)(5)(A).” Molina v.
10 Astrue, 674 F.3d 1104, 1112 (9th Cir. 2012) (internal quotation marks omitted).

11 If the ALJ finds testimony as to the severity of a claimant’s pain and
12 impairments is unreliable, “the ALJ must make a credibility determination with
13 findings sufficiently specific to permit the court to conclude that the ALJ did not
14 arbitrarily discredit claimant’s testimony.” Thomas v. Barnhart, 278 F.3d 947, 958
15 (9th Cir. 2002). In doing so, the ALJ may consider testimony from physicians
16 “concerning the nature, severity, and effect of the symptoms of which [the
17 claimant] complains.” Id. at 959. If the ALJ’s credibility finding is supported by
18 substantial evidence in the record, courts may not engage in second-guessing. Id.

19 In evaluating a claimant’s subjective symptom testimony, the ALJ engages in
20 a two-step analysis. Lingenfelter v. Astrue, 504 F.3d 1028, 1035-36 (9th Cir.
21 2007). “First, the ALJ must determine whether the claimant has presented

23 ⁶ In her motion to alter judgment, the Commissioner argues that “the Court’s
24 summary finding that [the non-examining physicians’] opinions did not constitute
25 evidence is clearly error.” (Dkt. 21 at 12.) The Commissioner cites Thomas v.
26 Barnhart, 278 F.3d 947, 957 (9th Cir. 2002) for the proposition that “opinions of
27 non-treating or non-examining physicians may also serve as substantial evidence
28 when the opinions are *consistent with independent clinical findings or other*
evidence in the record.” (Emphasis added.) Here, the non-examining physicians’
opinions are not supported by other evidence in the record, as discussed above.

1 objective medical evidence of an underlying impairment [that] could reasonably be
2 expected to produce the pain or other symptoms alleged.” Id. at 1036. If so, the
3 ALJ may not reject a claimant’s testimony “simply because there is no showing that
4 the impairment can reasonably produce the *degree* of symptom alleged.” Smolen v.
5 Chater, 80 F.3d 1273, 1282 (9th Cir. 1996).

6 Second, if the claimant meets the first test, the ALJ may discredit the
7 claimant’s subjective symptom testimony only if he makes specific findings that
8 support the conclusion. Berry v. Astrue, 622 F.3d 1228, 1234 (9th Cir. 2010).
9 Absent a finding or affirmative evidence of malingering, the ALJ must provide
10 “clear and convincing” reasons for rejecting the claimant’s testimony. Lester v.
11 Chater, 81 F.3d 821, 834 (9th Cir. 1995); Ghanim v. Colvin, 763 F.3d 1154, 1163
12 & n.9 (9th Cir. 2014). The ALJ must consider a claimant’s work record,
13 observations of medical providers and third parties with knowledge of claimant’s
14 limitations, aggravating factors, functional restrictions caused by symptoms, effects
15 of medication, and the claimant’s daily activities. Smolen, 80 F.3d at 1283-84 &
16 n.8. “Although lack of medical evidence cannot form the sole basis for discounting
17 pain testimony, it is a factor that the ALJ can consider in his credibility analysis.”
18 Burch v. Barnhart, 400 F.3d 676, 681 (9th Cir. 2005).

19 The ALJ may also use ordinary techniques of credibility evaluation, such as
20 considering the claimant’s reputation for lying and inconsistencies in his statements
21 or between his statements and his conduct. Smolen, 80 F.3d at 1284; Thomas, 278
22 F.3d at 958-59.⁷

24 ⁷ The Social Security Administration (“SSA”) recently published SSR 16-3p,
25 2016 SSR LEXIS 4, Policy Interpretation Ruling Titles II and XVI: Evaluation of
26 Symptoms in Disability Claims. SSR 16-3p eliminates use of the term “credibility”
27 from SSA policy, as the SSA’s regulations do not use this term, and clarifies that
28 subjective symptom evaluation is not an examination of a claimant’s character.
Murphy v. Comm’r of Soc. Sec., 2016 U.S. Dist. LEXIS 65189, at *25-26 n.6 (E.D.
Tenn. May 18, 2016). SSR 16-3p took effect on March 16, 2016, and therefore is

1 **2. Analysis.**

2 The ALJ did not articulate a clear rationale for finding that Plaintiff's
3 subjective reports of pain were not credible. The only explicit finding by the ALJ
4 that appears to relate to Plaintiff's credibility concerns Plaintiff's migraines, for
5 which the ALJ found Plaintiff had only received routine or conservative treatment.
6 AR 26. As a general matter, this can be a reason for finding a plaintiff's reports of
7 pain not fully credible. See generally Parra v. Astrue, 481 F.3d 742, 750-51 (9th
8 Cir. 2007) ("[E]vidence of 'conservative treatment' is sufficient to discount a
9 claimant's testimony regarding severity of an impairment."). Yet Plaintiff's
10 treatment for her back pain and radiculopathy cannot be characterized as routine or
11 conservative. It included two spinal fusion surgeries, regular physical therapy, two
12 types of injections, use of a lumbar support corset, and monthly visits with her
13 orthopedic surgeon. The finding that Plaintiff sought only routine treatment for her
14 migraines, one alleged side effect of her back injury, does not fully address her
15 complaints of pain and radiculopathy in her back and legs.

16 In the present action, the Commissioner points the Court to other portions of
17 the record that, the Commissioner argues, show the ALJ's credibility finding was
18 supported by substantial evidence.

19 a. Objective Medical Studies and the Non-Examining Physicians.

20 The Commissioner argues, first, that "the objective medical evidence
21 contradicted Plaintiff's allegations of debilitating pain and symptoms" and that
22 "Plaintiff's subjective complains were inconsistent with the State agency physician
23 opinions." (JS at 36-37.) As discussed above under Issue One, however, the
24 objective medical studies confirmed Plaintiff's reports of pain, and the ALJ did not
25 provide articulable reasons, supported by substantial evidence, for giving the non-
26 examining doctors' opinions greater weight than the opinion of Plaintiff's treating
27 _____
28 not applicable to the ALJ's 2014 decision in this case. Id.

1 physician.

2 b. Plaintiff's Daily Activities.

3 Second, the Commissioner argues that "Plaintiff's daily activities were
4 inconsistent with her allegations of disability." (JS at 37.) The ALJ did not
5 explicitly find that Plaintiff's reported daily activities were inconsistent with the
6 RFC proposed by Dr. Carlson or with total disability. Regarding her daily
7 activities, the ALJ found that Plaintiff "was able to take her children to and from
8 school, prepare meals, and do light housework but that she needed help with
9 grocery shopping. Further, she testified that she needed to take breaks in between
10 her activity and needed to walk around for about ten minutes after driving her
11 children to school, which took 20 minutes." AR 25. He also found, "She testified
12 that she had good days and bad days with about five bad days a month requiring her
13 to stay in bed all day." AR 25.

14 Regarding taking her children to and from school, Plaintiff testified that this
15 takes about 20 minutes round-trip, and when she gets home she has "to walk around
16 for a little while, at least, you know, ten minutes[.]" AR 43. She also testified that
17 generally, after sitting for 20 minutes, she needs to get up and move around for at
18 least 15 minutes to get comfortable again. AR 45. She further testified that she can
19 stand and walk for 15 or 20 minutes at a time but, "I have to take breaks. I'm not
20 able to do too much at a time." AR 40. She prefers "to be on [her] feet more than
21 sitting," but "[t]hirty minutes is about maximum before [she] can't stand it."
22 AR 45. After that, she testified, "I need to change positions, sit for a few minutes,
23 or lay down. Lay down is the best possible thing for me." AR 46.

24 Regarding housework and grocery shopping, she testified that she generally
25 does not go to the grocery store alone, unless she is buying only one or two items,
26 "because [she] can't carry the bags." AR 43-44. She does not lift more than 10
27 pounds because she has "been told not to," but "[i]t starts to hurt at a gallon of
28 milk." AR 44. Her daughter does the mopping, sweeping, and vacuuming around

1 the house. AR 43. She testified that she has good days and bad days; on a good
2 day she can go to the grocery store with her kids, and on a bad day she is “in bed
3 most of the day.” AR 41, 43.

4 Overall, Plaintiff’s testimony is not inconsistent with the portions of Dr.
5 Carlson’s proposed RFC that are at issue here, namely: that Plaintiff would need to
6 change positions as needed and take unscheduled breaks, and that she would likely
7 be absent from work about 2 days per month. AR 935-39. Her testimony
8 describing her daily activities does not provide substantial evidence for discounting
9 her subjective reports of pain or Dr. Carlson’s opinion.

10 c. Observations by Dr. Carlson.

11 Plaintiff argues that the “ALJ made no attempt to consider the testimony of
12 [Plaintiff] in conjunction with Dr. Carlson[’s] ... record or the medical evidence
13 showing the physical decline of her abilities and functioning from when she
14 stopped working to the present.” (JS at 34.) The Court agrees.

15 An ALJ should consider “*observations of treating and examining physicians*
16 and other third parties regarding, among other matters, the nature, onset, duration,
17 and frequency of the claimant’s symptom; precipitating and aggravating factors;
18 functional restrictions caused by the symptoms; and the claimant’s daily activities.”
19 Smolen, 80 F.3d at 1284 (emphasis added) (citing SSR 88-13). “[A]n ALJ does not
20 provide clear and convincing reasons for rejecting an examining physician’s
21 opinion by questioning the credibility of the patient’s complaints where the doctor
22 does not discredit those complaints and supports his ultimate opinion with his own
23 observations.” Ryan v. Comm’r of Soc. Sec., 528 F.3d 1194, 1199-200 (9th Cir.
24 2008). “This holding applies with no less force to the opinions of treating
25 physicians.” Page v. Comm’r of Soc. Sec. Admin., 304 F. App’x 520, 521 (9th Cir.
26 2008).

27 It is clear from Dr. Carlson’s treatment records that he believed Plaintiff’s
28 reports of disabling pain. There are no notes indicating that he suspected Plaintiff

1 of malingering or exaggerating her symptoms. In fact, in July 2011, Dr. Carlson
2 noted that Plaintiff was “very motivated” to get back to her prior work as a nurse.
3 AR 653-54. See Stivers v. Colvin, 2016 WL 889905, at *6 (S.D. Cal. Mar. 9,
4 2016) (“Notably in this case, none of the many doctors and specialists treating or
5 examining Plaintiff indicate any suspicion that Plaintiff may be malingering or
6 ‘overstating the intensity, persistence or limiting effects’ of her problems.”).
7 Moreover, as discussed supra under Issue One, Plaintiff’s reports of pain were
8 supported by Dr. Carlson’s own observations during physical exams, as well as
9 objective tests like x-rays and CT scans. Thus, “there is substantial objective and
10 reliable medical evidence in the record to support the severity of plaintiff’s
11 disabling pain allegations.” Jahn-Derian v. Metro. Life Ins. Co., No. CV 13-7221
12 FMO (SHX), 2016 WL 1355625, at *8 (C.D. Cal. Mar. 31, 2016) (rejecting ALJ’s
13 attempt to dismiss the medical records and observations of the plaintiff’s treating
14 doctor “as mere reiterations of [the plaintiff’s] subjective complaints of pain,”
15 noting the plaintiff’s back surgery, objective test results that explained that
16 explained the cause of the pain, and that the plaintiff’s treating doctor “documented
17 his observation of [the plaintiff’s] pain symptoms through frequent, ongoing
18 interactions”).

19 **C. Remand for an Award of Benefits is Appropriate.**

20 **1. Applicable Law.**

21 Upon review of the Commissioner’s decision denying benefits, this Court has
22 “power to enter ... a judgment affirming, modifying, or reversing the decision of
23 the Commissioner of Social Security, with or without remanding the cause for a
24 rehearing.” 42 U.S.C. § 405(g). If additional proceedings can remedy defects in
25 the original administrative proceeding, a Social Security case usually should be
26 remanded. Garrison v. Colvin, 795 F.3d 995, 1019 (9th Cir. 2014). However,
27 courts will sometimes reverse and remand with instructions to calculate and award
28 benefits “when it is clear from the record that a claimant is entitled to benefits,

1 observing on occasion that inequitable conduct on the part of the Commissioner can
2 strengthen, though not control, the case for such a remand.” Id.

3 In Varney v. Secretary of Health and Human Services (“Varney II”), 859
4 F.2d 1396 (9th Cir. 1988), the Ninth Circuit adopted the “credit-as-true” rule: that
5 is, “if the Secretary fails to articulate reasons for refusing to credit a claimant’s
6 subjective pain testimony, then the Secretary, as a matter of law, has accepted that
7 testimony as true.” Id. at 1398. In Hammock v. Bowen, 879 F.2d 498 (9th Cir.
8 1989), the Ninth Circuit held that the credit-as-true rule applies to medical opinion
9 evidence, not only claimant testimony. Id. at 503; see also Garrison, 759 F.3d at
10 1022 (applying credit-as-true rule where ALJ failed to provide legally sufficient
11 reasons to reject Garrison’s testimony and the opinions of her treating and
12 examining medical caretakers). “[T]he purpose of the credit-as-true rule is to
13 discourage ALJs from reaching a conclusion about a claimant’s status first, and
14 then attempting to justify it by ignoring any evidence in the record that suggests an
15 opposite result.” Vasquez v. Astrue, 572 F.3d 586, 594 (9th Cir. 2009). “By
16 requiring the ALJ to specify any factors discrediting a claimant at the first
17 opportunity, the rule ensures that pain testimony is carefully assessed, and helps
18 prevent unnecessary duplication in the administrative process.” Id. (internal
19 citation omitted).

20 The rule does not apply in all cases, however. Varney II “was specifically
21 limited to cases ‘where there are no outstanding issues that must be resolved before
22 a proper disability determination can be made, and where it is clear from the
23 administrative record that the ALJ would be required to award benefits if the
24 claimant’s excess pain testimony were credited.’” Vasquez, 572 F.3d at 593
25 (quoting Varney II, 859 F.2d at 1401). In Garrison, the Ninth Circuit laid out three
26 criteria that, if met, warrant application of the credit-as-true doctrine:

- 27 (1) the record has been fully developed and further administrative
28 proceedings would serve no useful purpose; (2) the ALJ has failed to

1 provide legally sufficient reasons for rejecting evidence, whether
2 claimant testimony or medical opinion; and (3) if the improperly
3 discredited evidence were credited as true, the ALJ would be required
4 to find the claimant disabled on remand.

5 759 F.3d at 1020. In evaluating the first issue, courts “consider whether the record
6 as a whole is free from conflicts, ambiguities, or gaps, whether all factual issues
7 have been resolved, and whether the claimant’s entitlement to benefits is clear
8 under the applicable legal rules.” Treichler v. Comm’r of Soc. Sec. Admin., 775
9 F.3d 1090, 1103-04 (9th Cir. 2014).

10 The Ninth Circuit has, “in a number of cases, stated or implied that it would
11 be an abuse of discretion for a district court not to remand for an award of benefits
12 when all of these conditions are met.” Garrison, 759 F.3d at 1020. Despite this, the
13 Ninth Circuit has also stated that district courts have some “flexibility” in deciding
14 whether to apply the rule. Id. at 1020-21 (discussing Connett v. Barnhart, 340 F.3d
15 871 (9th Cir. 2003)); see also Treichler, 775 F.3d at 1100 (noting that district courts
16 have discretion in deciding whether to remand for further proceedings or an award
17 of benefits, and that this decision “is a fact-bound determination that arises in an
18 infinite variety of contexts”). District courts should “remand for further
19 proceedings when, even though all conditions of the credit-as-true rule are satisfied,
20 an evaluation of the record as a whole creates serious doubt that a claimant is, in
21 fact, disabled.” Garrison, 759 F.3d at 1021.

22 Moreover, “[T]here are other factors which may justify application of the
23 credit-as-true rule, even where application of the rule would not result in the
24 immediate payment of benefits.” Vasquez, 572 F.3d at 593. For example, where
25 the claimant is “of advanced age and ha[s] already experience a severe delay in her
26 application,” the Ninth Circuit has applied the credit-as-true rule. Id. (applying
27 credit-as-true rule where the plaintiff was 58 years old and had applied for benefits
28 in October 2002, 6 years before the Ninth Circuit’s decision); see also Hammock,

1 879 F.2d at 503.

2 **2. Analysis.**

3 The Court finds that the three-part test articulated in Garrison has been met.
4 First, the record has been fully developed and further administrative proceedings
5 would serve no purpose. See Garrison, 759 F.3d at 1021 (“[A] remand for the
6 purpose of allowing the ALJ to have a mulligan” is not “a remand for a ‘useful
7 purpose’ under the first part of credit-as-true analysis.”). Second, as discussed
8 supra, the ALJ has failed to provide legally sufficient reasons for rejecting the
9 medical opinion of Dr. Carlson, Plaintiff’s treating physician, and for rejected
10 Plaintiff’s testimony regarding her pain. Third, if the improperly discredited
11 evidence (Dr. Carlson’s opinion and Plaintiff’s pain testimony) were credited as
12 true, the ALJ would be required to find the claimant disabled on remand. The
13 vocational expert specifically testified that the RFC given by Dr. Carlson would
14 preclude work. AR 50-51. See Brewes v. Comm’r of Social Sec. Admin., 682 F.3d
15 1157, 1164-65 (9th Cir. 2012) (remanding for award of benefits where the
16 vocational expert testified that a person with the plaintiff’s characteristics was not
17 employable). Compare Rivera v. Colvin, 2014 WL 6966328, at *6 (C.D. Cal. Dec.
18 8, 2014) (“Remand for further proceedings is warranted here because the vocational
19 expert did not testify that a person could not work with the limitations described by
20 Dr. Sobol and consequently the third Garrison condition has not been met.”).

21 In her motion to alter judgment (Dkt. 21), the Commissioner argues that
22 remand for further proceedings, rather than for an award of benefits, is appropriate
23 for several reasons. The Court addresses these reasons below.

24 a. The Court Has Examined the Record as a Whole.

25 The Commissioner argues that the Court erred because, after finding that the
26 ALJ’s stated reasons for discrediting Dr. Carlson’s opinion and Plaintiff’s
27 testimony were inadequate, the Court failed to examine the record as a whole.
28 “When a court assesses whether to credit evidence,” the Commissioner argues, “all

1 of the record evidence is at play, not just evidence that the ALJ discusses or
2 evidence that most favor's the plaintiff's position." (Dkt. 21 at 7.) While there is
3 some authority contradicting this proposition, see Garrison, 759 F.3d at 1022 n.31
4 ("Although we do so here, we do not mean to suggest that, in every credit-as-true
5 case, courts must undertake an independent review of the entire record."), this
6 Court *has* examined the record as a whole, not merely the evidence cited by the
7 ALJ.

8 For example, the only reasons the ALJ expressly gave for assigning Dr.
9 Carlson's opinion little weight were inconsistencies with Dr. Carlson's treatment
10 notes, the objective studies, and Dr. Carlson's earlier opinion. AR 27. The Court
11 nevertheless has considered whether other evidence in the record—particularly Dr.
12 Halbridge's June 2013 report and the opinions of the non-examining physicians,
13 which the Court finds to be the most relevant other evidence—provided substantial
14 evidence for assigning Dr. Carlson's opinion little weight. As discussed above (at
15 pages 19-23), the Court finds that they do not. The Court has also undertaken an
16 exhaustive review of all of Dr. Carlson's treatment notes, not merely the notes (or
17 portions thereof) cited in the ALJ's decision, as discussed above (at pages 16-18).

18 b. There are No Material Conflicts or Ambiguities in the Record
19 that Warrant Remand for Further Proceedings.

20 The Commissioner argues that the record "presents 'outstanding issues that
21 must be resolved before a determination of disability can be made.'" (Dkt. 21 at 8,
22 citing Benecke v. Barnhart, 379 F.3d 587, 593 (9th Cir. 2004)). Generally, unless
23 the ALJ is completely remiss in his or her duties, there will always be *some*
24 evidence in the administrative record that supports the ALJ's decision. The
25 presence of some evidence that supports the decision, and some evidence that does
26 not support it, does not automatically create a material conflict that forbids remand
27 for an award of benefits. The issue is whether further proceedings would "serve [a]
28 useful purpose." Garrison, 759 F.3d at 1020.

1 This case does not include the kind of factual conflicts at issue in, for
2 example, Treichler, on which the Commissioner heavily relies. There the Ninth
3 Circuit found “crucial questions as to the extent of Treichler’s impairment given
4 inconsistencies between his testimony and the medical evidence in the record.” 775
5 F.3d at 1105. These inconsistencies included: (1) medical records that “consistently
6 report[ed] that the [urinary] incontinence issue occur[red] at night, while Treichler
7 claim[ed] that he regularly ha[d] daytime problems”; and (2) medical records that
8 showed no “evidence of complaints to his doctors or other medical professional
9 regarding fecal incontinence,” while he claimed to have fecal incontinence once or
10 twice a month. Id. at 1104. This type of conflict, concerning the basic facts of
11 Plaintiff’s alleged conditions, is not present here. The ambiguities to which the
12 Commissioner points illustrate this.

13 First, the Commissioner argues that because some of Dr. Carlson’s treatment
14 notes are consistent with his RFC opinion but some show more benign findings, the
15 case must be remanded for the ALJ to re-consider the treatment notes. (Id. at 9-10.)
16 “[A] remand for the purpose of allowing the ALJ to have a mulligan” is not “a
17 remand for a ‘useful purpose’ under the first part of credit-as-true analysis.”
18 Garrison, 759 F.3d at 1021. As discussed above, the ALJ previously examined the
19 treatment notes and cherry-picked language that appeared inconsistent with Dr.
20 Carlson’s opinion. After the Court examined the treatment notes as a whole,
21 however, it determined that they were not inconsistent with Dr. Carlson’s opinion.
22 There is no factual ambiguity about the notes to be resolved on remand.

23 Second, the Commissioner points to the Court’s discussion of the February
24 2011 MRI (see above at pages 10-13). The ALJ pronounced the MRI inconsistent
25 with Dr. Carlson’s opinion because it did not show spinal canal or foraminal
26 stenosis, without discussing evidence indicating that the MRI was of poor quality or
27 later objective tests showing stenosis. The Commissioner argues that this other
28 evidence “represent[s] exactly the ‘conflicts and ambiguities’ that warrant further

1 administrative proceedings.” (Dkt. 21 at 10.) Again, remanding for the ALJ to re-
2 consider this evidence, which the ALJ already had an opportunity to review, would
3 simply be allowing the ALJ to have a second bite at the apple. After examining all
4 of the objective tests in the record, the Court has found that they do not provide a
5 basis for discounting Dr. Carlson’s opinion.

6 Third, the Commissioner argues that remand for further proceedings is
7 appropriate to resolve conflicts between Dr. Carlson’s opinion and the opinion of
8 the worker’s compensation doctor and the non-examining State agency physicians.
9 (Dkt. 21 at 12-14.) However, as discussed above (at pages 19-23), it was legal error
10 for the ALJ to give the opinions of Drs. Amon, Medina, and Halbridge more weight
11 than the opinion of Plaintiff’s treating physician, because there was not substantial
12 evidence in the administrative record as a whole to support this.

13 In sum, the Court concludes that Plaintiff has satisfied all three conditions of
14 the credit-as-true rule and that a careful review of the record as a whole discloses no
15 reason to seriously doubt that she is, in fact, disabled. A remand for a calculation
16 and award of benefits is therefore appropriate.

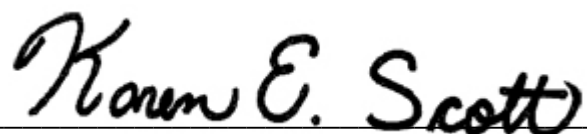
17 **V.**

18 **CONCLUSION**

19 Based on the foregoing, IT IS ORDERED that the Judgment entered on
20 March 10, 2017 (Dkt. 20), which reverses the decision of the Commissioner
21 denying benefits and remands for the Commissioner to calculate and award
22 benefits, shall remain in effect.

23 IT IS FURTHER ORDERED that the Commissioner’s Motion to Alter
24 Judgment (Dkt. 21) is DENIED.

25 DATED: June 02, 2017

26 
27

28 KAREN E. SCOTT
United States Magistrate Judge